MassHealth

Commonwealth of Massachusetts
EOHHS
www.mass.gov/masshealth

Uncompensated Care Pool Eligibility Review Form

For office use only (WAIVER)

Date received:

You and members of your household were determined to be eligible for full or partial payment of your medical bills at a hospital or community health center under the Uncompensated Care Pool (UCP). The answers on this review form will be used to find out if you are still eligible to have your health-care providers' charges paid by the UCP.

The information you give us is kept confidential, as required by state and federal laws.

Please answer all questions and fill out all sections that apply to you and your household. If you need more space in any section, give us the information on a separate sheet of paper and attach it to this review form.

If you have any questions about this review form or the information you need to send, please call the MassHealth/UCP Review Team at 1-800-795-1922 (TTY: 1-800-723-7779 for people with partial or total hearing loss).

Head of Household Information

HOH

Last name	First name	MI	Street address

City	State	Zip	Mailing address *(if different from street address or if living in a shelter)*

Social security number*	Date of birth	Gender
	/ /	☐ Male ☐ Female

Race *(optional)*	Spoken language	Written language	Ethnicity *(optional)*

Telephone numbers *(List work number only if we can call you at work.)*

Home: ( ) Work: ( )

Other Household Members Information

HOH

Please answer the following questions. **(Note: When filling out this section, please look at the cover letter (that was sent with this form) that lists the members of your household you listed on your original application.)**

- How many members are living in your household now? _____ (This number includes you, your spouse, and any dependents under age 19 now living with you.)
- Have any new members joined your household in the past 12 months? ☐ yes ☐ no

If **yes**, fill out this section.

Name	Is this person applying?	Social security number*	Date of birth	Gender	Relationship to head of household
	☐ yes ☐ no		/ /	☐ Male ☐ Female	
	☐ yes ☐ no		/ /	☐ Male ☐ Female	

- Have any members left your household in the past 12 months? ☐ yes ☐ no

If **yes**, fill out this section.

Name	Social security number*	Date of birth	Gender	Relationship to head of household
		/ /	☐ Male ☐ Female	

*List only if one has been issued.

Fill out the Working and Nonworking Income Information sections on the other side of this page, then sign and date the form.

Working Income Information

EIN

▶ List the working income for you or any family member in the section below.

☒ **Send proof** of income, like a copy of two recent pay stubs, a copy of your most recent federal tax return with attachments, or a statement from your employer.

1. **Name**

Employer name, address, and telephone number	Type of work *(Check all that apply.)*			**For office use only** (indicate weekly, biweekly, or monthly)	
	☐ full-time ☐ part-time ☐ self-employed	☐ day labor ☐ seasonal yearly wage: $ _____	☐ sheltered workshop yearly wage: $ _____	$	
				$	

Is health insurance offered?*	Number of hours per week	Weekly pay before deductions	Date began getting this amount of pay	HID		
☐ yes ☐ no		$	/ /		Hrs.	
					Hrs.	

2. **Name**

Employer name, address, and telephone number	Type of work *(Check all that apply.)*			**For office use only** (indicate weekly, biweekly, or monthly)	
	☐ full-time ☐ part-time ☐ self-employed	☐ day labor ☐ seasonal yearly wage: $ _____	☐ sheltered workshop yearly wage: $ _____	$	
				$	

Is health insurance offered?*	Number of hours per week	Weekly pay before deductions	Date began getting this amount of pay	HID		
☐ yes ☐ no		$	/ /		Hrs.	
					Hrs.	

* Check yes even if you cannot get it now.

Nonworking Income Information

UIN

▶ List the nonworking income, like child support, unemployment compensation, rental income, or a pension, for you or any family member in the section below.

▶ Please describe the type and source (where it comes from) of the income for each family member.

☒ **Send** a statement from the source of the income. You do not have to send proof of social security or SSI income.

Name	Type and source (where it comes from) of income	Monthly amount before taxes	**For office use only**

Signature

I certify under penalty of perjury that the information on this form is correct and complete to the best of my knowledge. I understand that I must tell MassHealth of any changes in income or employment, family size, address, health insurance, and immigration status, or of changes in any other information given on this review form within 10 days of learning of the change.

I understand that MassHealth may check the information given on this review form with the Massachusetts Department of Revenue, the Social Security Administration, and/or other state and federal agencies.

The head of household, all persons aged 18 or older, and all parents of any age who have children living with them who are getting or want to get Uncompensated Care Pool benefits, must read this signature section carefully, then sign and date below. If you are signing below as an eligibility representative, a filled-out MassHealth Eligibility Representative Designation Form must also be submitted or already be on file with MassHealth.

_____ _____

Signature of member or eligibility representative Date

_____ _____

Signature of member or eligibility representative Date